Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 12/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 21044 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 11/18/09 to 12/14/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 150 total beds, 120 elderly or disabled persons, and/or persons with mental illnesses, and/or persons with chronic illnesses, and 30 persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 109. Five resident files were reviewed Complaint #NV00023603 was substantiated. See Tag Y593. Complaint #NV00023327 was substantiated. See Tag Y850. Complaint #NV00023624 was substantiated. See Tag Y050. Complaint #NV00023622 was substantiated. See Tag Y593. Complaint #NV00023538 and NV00023444 were substantiated. See Tag Y590. The following deficiencies were identified:	Y 000		
Y 050 SS=J	449.194(1) Administrator's Responsibilities-Oversight	Y 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 050	Continued From page 1 NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. This Regulation is not met as evidenced by: Surveyor: 21044 Based on record review and interviews from 11/18/09 to 12/8/09, the administrator failed to ensure staff attended to the needs of 1 of 109 residents. Findings include: Resident #4 was admitted to the facility on 5/18/2008. A 12/3/07 physician history and physical indicated the resident was diagnosed with chronic pulmonary obstructive disease (COPD), hearing loss, hypertension, coronary artery disease with a pacemaker and bladder neck obstruction. The resident's record was reviewed and revealed the resident had experienced three hospitalizations for a recurrent left inguinal hernia in July of 2008, September of 2009 and November of 2009. Resident #4 was interviewed regarding his last	Y 050		

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Y 050	Continued From page 2 hospitalization on 11/11/09. The resident reported that he hurt his hernia trying to plunge his toilet which had backed up. The resident reported that when his toilet clogged up in the past, he would tell a staff person and they would take care of it. The resident stated the day he hurt himself the toilet had backed so he went down to the medication room to tell a staff person, but the line was too long and he gave up. The resident did remember asking someone to help him, but could not recall which caregiver he spoke to. The Wellness Coordinator, Employee #1, was interviewed about the incident. The Wellness Coordinator reported that after investigating the incident, she discovered a caregiver was approached by Resident #4 to help fix his toilet. The caregiver told the Wellness Coordinator that he was in the middle of something and could not help the resident and made a mental note to himself to go back to the resident's room when he was finished. When the caregiver finally went to the resident's room, the resident was asleep, so he left a toilet plunger by the bathroom for the resident to find when he woke up. The Wellness Coordinator reported the caregiver did not plunge the toilet for the resident. The Wellness Coordinator stated that on 11/11/09, a medication technician called her to report the resident was having testicular pain and the caregiver was instructed to call the ambulance. The Wellness Coordinator further reported the night the incident happened, there were two medication technicians and four caregivers on duty, so they would have had time to plunge the toilet for the resident. Five caregivers were interviewed about the incident. One caregiver was aware that Resident #4 had hernia problems because his testicles	Y 050		

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Y 050	Continued From page 3 would swell up to the size of a grapefruit occasionally. All of the caregivers reported they would never let a resident plunge a toilet even if he asked for a plunger. The caregivers stated it was not the job of the resident to fix their own toilets; it was the staff's responsibility. They all reported they would either plunge the toilet themselves or have housekeeping or maintenance do it. The maintenance supervisor reported that maintenance was not in the building twenty-four hours a day, so caregivers were responsible for plunging toilets if needed. Resident #4's daughter was interviewed about her father's latest hospitalization. The daughter reported the facility knew her dad had a hernia problem because he had been transported to the hospital a couple of times for it in the past year. The daughter stated the morning of her father's 11/11/09 hospitalization, a staff person called her saying her father was complaining of abdominal pain and that his toilet overflowed and they would fix it. The daughter reported she learned later that her father had attempted to plunge the toilet himself and worsened his hernia. She stated that while in the hospital for three days, her father received morphine sulfate which caused the hernia to reduce, so they did not need to operate. She further stated that if staff had plunged the toilet when asked, her father would not have been hospitalized again. The daughter reported that she depended on the staff to fix things. Severity: 4 Scope: 1	Y 050		
Y 590 SS=J	449.268(1)(a) Resident Rights NAC 449.268	Y 590		

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Y 590	Continued From page 4 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Surveyor: 21044 Based on record review and interviews from 11/18/09 to 12/8/09, the administrator did not prevent 1 of 109 residents from being neglected. Findings include: According to home health agency interviews, Resident #5 had been receiving colostomy and wound care services for a couple of years prior to being admitted in the facility. The home health agency's records revealed the agency had been caring for the resident's chronic non-healing Stage IV coccygeal wound since 8/31/07. Both the home health agency licensed practical nurse (LPN) and registered nurse (RN) reported when the resident lived in a smaller group home, she was capable of managing her colostomy bag without assistance, was mentally stable and clean. The resident's son verified the nurses' comments about his mother's ability to care for her colostomy herself and the coccygeal wound. The son reported he had to move his mother from the smaller group home because it closed and further added that his mother was in great shape and could walk before she was admitted to the larger assisted living facility.	Y 590		

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Y 590	Continued From page 5 Record review revealed Resident #5 was admitted to the facility on 8/25/09 needing colostomy care and twice weekly wound care. The 8/26/09 admission note indicated the resident was alert and oriented to person and could ambulate independently with a walker. Computerized medication administration records (MAR) indicated Resident #5 did not receive the following medications on the listed dates: Effexor XR 75mg daily (used for the treatment of major depressive disorder, anxiety, and panic disorder) - 8/26/09, 9/1/09, 9/2/09, 9/6/09, 9/8/09, 9/9/09, 9/10/09, 9/11/09, 9/12/09, 9/13/09, 9/15/09, 9/16/09, 9/17/09, 9/18/09, 9/21/09, 9/22/09, 9/24/09, 9/25/09, 9/26/09, and 9/28/09 - twenty doses. Namenda 10mg daily at bedtime (used for the treatment of dementia associated with Alzheimer's disease) - 8/28/09, 8/29/09, 9/4/09, 9/7/09, 9/14/09, 9/28/09, and 10/13/09 - seven doses. Zolpidem 5mg daily at bedtime (used for short term treatment of insomnia) - 8/28/09, 8/29/09, 9/4/09, 9/7/09, 9/14/09, and 9/25/09 - six doses. Sular 34mg daily (used for the treatment of hypertension) - 9/1/09, 9/2/09, 9/6/09, 9/8/09, 9/9/09, 9/10/09, 9/11/09, 9/12/09, 9/13/09, 9/16/09, 9/17/09, 9/18/09, 9/21/09, 9/24/09, 9/25/09, 9/26/09, 9/28/09, and 10/13/09 - eighteen doses. Aricept 10mg daily (used for the treatment of mild dementia associated with Alzheimer's disease) - 8/26/09, 9/8/09, and 9/18/09 - three doses. Calcium Citrate/Vitamin D daily (used for the treatment of a vitamin and mineral deficiency) - 9/8/09 and 9/18/09 - two doses. A medication technician was interviewed	Y 590		

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Y 590	Continued From page 6 regarding the missing medications and she reported she went to her supervisors for help and no one would help her with Resident #5's missing medications. The medication technician stated the former Wellness Director and Executive Director knew about the medication situation, but nothing happened. The facility has been cited in the past for not ensuring residents receive their medications as prescribed. Multiple caregivers were interviewed regarding Resident #5's condition while a resident on the assisted living side of the facility from 8/25/09 to 10/13/09. One caregiver reported when the resident was first admitted, she would walk around a lot, would talk and converse with everyone and only needed to be reminded to go to the dining room. One caregiver reported the resident was not capable of caring for the colostomy because she would wipe the stoma on the dining room table cloth and stuff the colostomy bag with tissues. The caregiver reported it was difficult to clean the resident up after such incidents because the resident hated to be showered and struggled with caregivers. Two caregiver reported they complained that the resident needed another evaluation on whether she could care for her own colostomy to both home health nurses and to management. A medication technician stated the resident also began to wander more, became more confused and needed more care so staff started taking her over to the memory care unit during the day to prepare her for an eventual transfer to that unit. All of the caregivers interviewed did not recall the resident having a Stage IV wound on her coccyx despite reports they bathed her and took her to the bathroom to urinate. The home health nurses caring for the wound were surprised to hear that none of the caregivers could recall the wound	Y 590		

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Y 590	Continued From page 7 because it was very visible (averaged 1.8 cm long X 1.4 cm wide X 1 cm deep with/ tunneling) and had a yellow/brownish discharge. The RN stated she could not believe the caregivers did not know about decubitus and said, "If you bathed her, you would have to see it." Resident #5's son was interviewed regarding his mother going over to the memory care unit during the day while still residing on the assisted living side of the facility. The son stated facility staff called it, "Day Tripping" and he was okay with the practice because it was to get his mother used to the unit before actually transferring her there. The home health LPN, primarily responsible for the resident's wound and colostomy care on the assisted living side, reported she remembered the resident being over on the memory care unit side "Day Tripping" during the day and she treated her three times in that unit. The LPN remembered the resident did not like being in the memory care unit because she could not take a nap. The LPN stated memory care staff kept her up in a wheelchair all day which upset the resident. During the LPN's last visit with the resident on 10/8/09, she reported the resident was very agitated and felt the resident's dementia had worsened. On 10/13/09, Resident #5 was formally transferred to the memory care unit called Sara's Garden. A review of the resident's MAR after she was transferred to the memory care unit was attempted, but the facility could only located a paper MAR for the time period of 10/24/09 to 10/31/09. The facility has been unable to provide a MAR for the time period from 10/14/09 to 10/23/09 - a period of nine days. The paper MAR from 10/24/09 to 10/31/09 indicated the resident refused all of her medications on 10/25/09,	Y 590		

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Y 590	Continued From page 8 10/26/09, 10/27/09, 10/28/09 and 10/29/09. A home health RN reported the last time she saw Resident #5 on the assisted living side was on 10/12/09. The RN remembered the resident's diaper was dirty and wet, her clothes and bedding were dirty, and she smelled of urine. The RN reported she told the staff to bathe the resident. The same home health RN reported she next saw Resident #5 on 10/27/09 in the memory care unit. The RN stated she noticed the resident was missing her special mattress pad because it was not on her bed. The RN related that she told the caregiver to find the mattress because the resident had it on the bed when she lived on the assisted living side. The RN stated she found the resident screaming in bed for help, covered in feces because she had no colostomy bag on and with her diaper soaking wet. The RN told the medication technician to find the resident's ostomy supplies, but the technician could not find any. The RN also reported that she discovered two new pressure ulcers on the resident's buttocks and she instructed caregivers to bathe the resident and care for her better. The RN further reported she noticed the resident seemed more agitated than the last visit on 10/12/09, her blood pressure was low, her lips were dry and cracked, she was complaining of being very thirsty, and asked her for water. The RN also stated she instructed caregivers to give the resident more fluids along with caring for her better. The RN stated she felt the resident's condition was markedly deteriorated since her last visit of two weeks ago and she notified her supervisor and the social worker. At the prior group home, the RN reported the resident could manage her own colostomy, she was stable mentally and was clean. Since coming to the	Y 590		

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Y 590	Continued From page 9	Y 590		

facility, "she just fell apart." Two memory care unit caregivers were interviewed about the coccygeal wound and neither recalled the Stage IV coccygeal wound or the two smaller decubitus ulcers the RN had noticed on her 10/27/09 visit.

During an interview with the new Executive Director and Wellness Director, Employee #1, both reported they discharged Resident #5 to the hospital as the resident did not meet criteria to remain in the facility because of her colostomy and wound care issues. The resident was transferred to a local hospital on 10/28/09 and admitted with acute renal (kidney) failure, hypernatremia (high sodium levels), leukocytosis (elevated white blood cell counts), hypotension (low blood pressure), a sacral decubitus ulcer, depression, dehydration, pneumonia and failure to thrive. A photograph was taken documenting the two new ulcers on the resident's buttocks. The resident was treated with intravenous fluids and antibiotics and was discharged from the hospital on 10/30/09 to a skilled nursing facility.

During an interview with Resident #5's son, the son reported that his mother's condition had improved since leaving the hospital. The resident is now in a skilled nursing facility and receiving her medications as prescribed. Since being admitted to the skilled nursing facility, the son reported that his mother's personality had changed and commented that his mother was "bright eyed and bushy tailed," was more alert, was learning to walk again and was eating 100% of her meals. The son further reported that his mother was in great shape before being admitted to the assisted living facility and just two months later she was in the hospital and not able to walk. The son felt facility staff had neglected his mother and if staff had made sure his mother received

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Y 590	Continued From page 10 her prescribed medications, she would not have declined to the point of needing hospitalization. Severity: 4 Scope: 1	Y 590		
Y 593 SS=G	449.268(1)(d) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment. This Regulation is not met as evidenced by: Surveyor: 21044 Based on observation and interviews from 11/18/09 to 12/14/09, the facility failed to ensure the facility was comfortable for 3 of 109 residents. Findings include: Resident #1 and #2: A complaint was received regarding a strong odor coming from bedroom #105. The bedroom was inspected at 7:00AM on 11/18/09 and a strong smell of male body odor was detected. The hallway outside the room had no odor and nor did the rooms adjacent to bedroom #105 (#126, #127 and #104). Resident #1 and #2 resided in bedroom #105. Resident #2 had been hospitalized for pneumonia on 11/10/09 and was unavailable for interview. Resident #1 was interviewed about the strong odor in the room and reported that he did not	Y 593		

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Y 593	Continued From page 11 smell anything, but complained about his roommate smelling and causing the room to smell because he never flushed the toilet. Resident #1 reported that he had complained to management that his roommate smelled and that he wanted to be transferred to another room, but no one had arranged a move. Four caregivers were interviewed about the smell coming from bedroom #105. None of the caregivers reported that anyone complained to them about a smell in the room and did not recall the room having a strong odor. The caregivers reported that Resident #2's son came everyday and never mentioned an odor in the room. Resident #2's daughter, reported on 12/3/09, that she visited her father frequently during his stay from 10/7/09 to 11/10/09. The daughter stated she complained to caregivers every other day since her father was admitted that the room "stank." The daughter further reported that she even brought in an air purifier to get rid of the smell and told staff what it was for, so staff were aware of the situation. When she complained to one caregiver, the caregiver reportedly told her that "a lot of rooms smell." The daughter stated that when she requested that her father be moved, she was told they could not move her father to another room because there were no rooms available. When her father was released from the hospital, the daughter stated she decided not to allow her father to return to the facility and when the family picked up her father's belongings, they "reeked." Resident #2 was not available to interview. The current Wellness Coordinator, reported that Resident #1 had complained about Resident #2 smelling up the room because he didn't flush the	Y 593		

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Y 593	Continued From page 12 toilet. The Wellness Coordinator stated the plan was to change rooms when Resident #2 returned from the hospital. The family of Resident #1 and Resident #2 had both complained of the odor in bedroom #105 and the facility made no effort to accommodate both parties and failed to ensure the two residents resided in a comfortable, odor free environment. Resident #6: Resident #6 was originally admitted to the facility on 7/24/09 and was transferred to the hospital on 8/4/09 after complaining of a painful left hip. Records revealed the resident had fractured her left hip. The resident was re-admitted to the facility on 8/25/09 after a stay in a rehabilitation hospital. The resident was also admitted to a hospice agency the same day she returned to the facility on 8/25/09. During an interview with Resident #6's son, he reported that after his mom returned to the facility in August on hospice care, he felt his mom's room was too hot. The son stated the ambient temperature in the room had to be in the mid-nineties. The son reported his mother's side of the room was the farthest from the only air conditioner in the apartment which she shared with another resident. The son stated he would turn up the air conditioner for his mom's comfort, but her roommate would turn it down. The son further reported that he would turn the ceiling fan on high because he had do something. The son stated he talked with the former Wellness Director daily about moving his mother to another room, but nothing happened. He also reported that he spoke to every hospice nurse and	Y 593		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 593	Continued From page 13 caregiver he met that the room was too hot. The son stated that once he even found his mother in a "pool of water." The son reported that his mother just had hip surgery, was on hospice care and he felt the heat in the room dehydrated her and caused her eventual decline. Various hospice nurses and certified nursing assistants were interviewed about Resident #6. The registered nurse (RN) that originally admitted the resident to hospice care on 8/25/09, reported the room was too warm that day because she remembered having to prop the door open to let some cool air into the room. Another RN reported the resident's sons had complained to her about the temperature in the room and she suggested they talk with facility management. The RN stated the sons told her they had already complained, but no one had gotten back to them yet. The RN recommended they bring in a fan to help until her room was changed. The RN also reported finding the resident naked in bed maybe in response to the heat in the room. A hospice certified nursing assistant (CNA) reported she saw the resident on 8/27/09 and 8/28/09. During the 8/27/09 visit, she thought the room was too warm and told a caregiver. The caregiver reportedly told her, "OK. We'll take care of it." Another hospice CNA reported that during one of her four visits, she found the resident in bed without her top on. The CNA stated the resident told her she was hot. Multiple caregivers were interviewed about the heat in Resident #6's room. None of the caregivers reported that Resident #6 or her family had complained about the heat in the room. Record review and interviews with caregivers and hospice staff revealed Resident #6 continued to	Y 593		

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Y 593	Continued From page 14 decline, but the family wanted her aggressively treated with intravenous fluids for her dehydration. As a result, the resident was transferred to a local hospital on 9/4/09. The record indicated the resident returned to the facility on 9/12/09 into a different room and hospice care was resumed. The resident's son reported his mother eventually passed away on 9/13/09. The family of hospice Resident #6 complained repeatedly to management about the temperature in their mother's room, but the facility neglected to ensure the room temperature was made comfortable for this dying resident for 10 days (8/25/09 to 9/4/09). Severity: 3 Scope: 1	Y 593		
Y 850 SS=J	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available. This Regulation is not met as evidenced by:	Y 850		

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Y 850	Continued From page 15 Surveyor: 21044 Based on record review and interviews from 11/18/09 to 12/8/09, the facility failed to ensure 1 of 109 residents received medical care after multiple nose bleeds. Findings include: Resident #3 was an 86 year old male who was a former patient of the Heights of Summerlin, a skilled nursing facility. A history and physical dated 4/11/09, while still a patient of the skilled nursing facility, indicated the resident had a history of atrial fibrillation with bradycardia, a stroke in 2007, deep vein thrombosis, hypertension, hypercholesterolemia, prostate cancer, dementia and a myocardial infarction. Prior to being discharged from the skilled nursing facility, two Protime tests (PT) to measure the amount of time it took for blood to start clotting, were conducted on 6/29/09 and 6/30/09. The results were 22.5 seconds on 6/29/09 and 17.4 seconds on 6/30/09. Normal PT values should be 11 to 14 seconds. Both lab reports were found in the new facility's record along with the 4/11/09 history and physical. Resident #3 was discharged from the Heights of Summerlin on 6/30/09. During an interview with the resident's son, he reported that when his father left the Heights of Summerlin, he left "with a clean bill of health" and was deemed appropriate for assisted living. The resident was admitted to the new facility on 7/2/09 with physician's orders for medications that included daily doses of Aspirin 325 milligrams (mg) in the morning and Coumadin 5 mg in the evening. The medication administration record indicated the resident received his Aspirin and Coumadin as	Y 850		

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Y 850	Continued From page 16 prescribed from 7/2/09 to 7/14/09. Facility records dated 7/10/09 at 10:30 AM revealed the following: - "Caregiver reported epistaxis (bloody nose) in dining room at breakfast. Resident checked and approximately 5 cc of light red color blood seen on table cloth and napkin. Epistaxis resolved spontaneously. Resident not currently bleeding." - "Resident is on Coumadin. Will monitor for continued problems. If nose bleed occurs again, will recommend be seen by MD for follow up and INR check." When a caregiver was interviewed about Resident #3, he remembered that Resident #3 had chronic nose bleeds for about a week and that he reported them about "a dozen times" during the resident's last five or six days in the facility to the facility nurse and his medication technician. The caregiver stated the nurse finally called the family. The caregiver also reported that he would find dried blood stains on the resident's clothes and when the resident leaned forward to eat, his nose would bleed at the dining room table. The caregiver further reported that he heard the family wanted to talk with him about the nose bleeds and he told them what he knew and he suggested to them that they have the resident checked out by a doctor. The current Executive Director, a nurse, reported that back in July she was a consultant with the facility. The Executive Director recalled recommending to the former Executive Director and former Wellness Director that Resident #3 be discharged to the hospital for an evaluation after two reports of a bloody nose. Resident #3's son reported in an interview that he	Y 850		

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Y 850	Continued From page 17 visited his father every other day and he also noticed evidence of a bloody nose and different caregivers would mention it to him too. The son reported staff told him his father had to be taken out of the dining room because his nose was bleeding and once his father's sheets had to be changed because he had bled all over them. The son commented that he was asked once if his father normally had bloody noses and he told them his father never had bloody noses. The son stated he did not know how often his father's nose would bleed because his father had dementia and could not tell him how frequently the nose bleeds were occurring. Toward the end of his father's stay in the facility, the son reported that he stopped by the medication room and asked a caregiver if anyone had called a doctor about his father's nose bleeds and was told, "No." The son reported that then he decided to call their family doctor and not wait on the facility to call. On 7/14/09, the family doctor's nurse called the facility about the nose bleeds and she reportedly told the son that facility staff asked her how to stop the bloody noses, so she was alarmed. The son reported the doctor's nurse then instructed facility staff to call an ambulance and within an hour an ambulance arrived and took his father to the hospital. Resident #3 was admitted to Summerlin Medical Center on 7/14/09 for epistaxis (bloody nose), anemia, gross hematuria (blood in the urine) and coagulopathy (clotting issues). The admission notes revealed the resident had clotted blood in his nostrils and a Foley urinary catheter which had gross blood in it. The resident also had widespread ecchymosis (bruising) throughout his right hip and had a hematoma (a large bruise) on his right hip. The physician noted the resident	Y 850		

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Y 850	Continued From page 18 would be transfused with two units of fresh frozen plasma and blood, be given Vitamin K and placed on telemetry. An admission lab report dated 7/14/09 at 1:05 PM indicated the resident's red blood cell count was 3.2 m/cmm (normal value is 4.5 to 6 m/cmm), his hemoglobin was 10.3 g/dl (normal value is 13.0 to 18 g/dl), and his hematocrit was 30.1 % (normal value is 39.0 to 54 % normal). A lab report dated 7/14/09 at 3:00 PM indicated his partial thromboplastin time (PTT) was 200 seconds (normal value is 22.0 to 34.0 seconds) and his International Normalized Ratio (INR) was 18.0 (normal value is 0.9 to 1.1). Resident #3's son reported his father was only in the facility for 13 days. The son stated facility staff knew his father was on Coumadin and Aspirin and was having bloody noses, but no one called the doctor or followed up on the bloody noses. The son also reported his father was supposed to have his blood drawn while in the facility by home health nurses, but a record review revealed no evidence the resident was receiving home health services or that services were initiated. The son further stated that after his father was stabilized at Summerlin Medical Center, he was discharged to a series of medical facilities, his health declined, he caught pneumonia and acquired bedsores and passed away on 10/26/09. Severity: 4 Scope: 1	Y 850		
Y 853 SS=D	449.274(3)(a) Medical Care / Records NAC 449.274 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be	Y 853		

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Y 853	Continued From page 19 made by the caregiver who first discovers the accident, injury or illness. the record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered. This record must accompany the resident if he is transferred to another facility. This Regulation is not met as evidenced by: Surveyor: 21044 Based on record review and interview from 11/18/09 to 12/8/09, the facility failed to prepare incident reports for 2 of 109 residents suffering an illnesses. Findings include: Resident #3 suffered multiple nose bleeds during a 13 day stay in the facility. See Tag Y850. The resident's record did not contain any incident reports documenting the nose bleeds. Resident #4 was hospitalized at least three times for a recurrent left inguinal hernia since his admission in 2008. See Tag Y050. The resident's record did not contain any incident reports regarding his hospitalizations. Severity: 2 Scope: 1	Y 853		